Texas Department of Aging
and Disability Services

Form 8654
January 2014

State Supported Living Center (SSLC)

Admission Application

Individual's Name
Admission Request ☐ **Voluntary** ☐ **Involuntary/Court Commitment** ☐ **Emergency Admission** ☐ **Respite Admission**

Instructions for Completing the Application:

No individual will be admitted for residential services without a complete application packet on file at the admitting SSLC. An application packet is considered complete when all three parts are completed, the application is signed, and the required documentation is attached to the application.

The Local Authority (LA) representative must be familiar with the most recent amendments to the Continuity of Services rule, Chapter 2, Subchapter F.

The completed application and application packet must be forwarded to the LA's servicing SSLC.

If for some reason the individual cannot be admitted to the servicing SSLC, the completed application with packet will be forwarded to an alternative SSLC.

I, _____, LA representative for _____, have read Section 2.265 of the Continuity of Service rule.

LA Representative Completing Application/Packet	Date	_ _ Area Code and Telephone Number

Part 1

(Demographic information) of this application is to be completed by the assigned LA with assistance from the individual, legally authorized representative (LAR) and/or other relative informants. This part requests basic identifying information of the individual to assist the SSLC with understanding the individual's needs.

Part 2

(Medical information) of this application is to be completed by the individual, LAR, family, current facility if applicable and his or her physician. This part requests information concerning the individual's health or medical history.

Part 3

(Financial information) of the application is to be completed by the individual and his or her family or LAR with assistance from a representative of the assigned LA. This part requests information regarding the individual's family history and financial status.

Individual or Legally Authorized Representative	Date

Legend

ARD - Admission Review and Dismissal	LAR - Legally Authorized Representative
CARE - Client Assignment and Registration System	LON - Level of Need
COS - Continuity of Service	MERP - Medicaid Estate Recovery Program
CRCG - Community Resource Coordination Group	LA - Local Authority
DID - Determination of Intellectual Disability	ID/RC - Intellectual and/or Related Conditions
DOB - Date of Birth	SL - Service Level
ICAP - Inventory of Client and Agency Planning	SSLC - State Supported Living Center
IDT - Interdisciplinary Team	SS Number - Social Security Number
IEP - Individual Education Plan	DADS - Texas Department of Aging and Disability Services

☐ **Court Commitment** ☐ **Voluntary Admission**

- ☐ Completed application for admission
- ☐ Original order of commitment, if applicable
- ☐ A DID meeting the requirements as set forth in Chapter 4, Subchapter D of the DADS rules
- ☐ A completed ICAP booklet with printout score sheet
- ☐ ID/RC Assessment form (CARE entry by LA on date of admission or within 15 working days)
- ☐ A complete IDT report recommending admission to the state residential facility (IDT must include appropriate LA staff)
- ☐ Psychological (include Behavior Program if applicable), Medical and Social History
- ☐ A certified copy of the applicant's birth certificate
- ☐ A copy of any divorce decree naming the applicant in its stipulation(s)
- ☐ A copy of the current letter of guardianship, a copy of the guardianship order, a copy of the application for guardianship (if applicable) and any power of attorney document
- ☐ A copy of the order for managing conservatorship or any legal document pertaining to the custody of a minor
- ☐ A copy of any wills naming the applicant as a party
- ☐ A copy of the applicant's immunization record
- ☐ A copy of applicant's Social Security card
- ☐ A copy of the applicant's Medicaid and Medicare card, including Part D provider and number, if applicable, and MERP Receipt Acknowledgement
- ☐ Any record regarding the care and treatment of the applicant in a state mental health facility, psychiatric hospital or residential facility
- ☐ A copy of any relevant legal documents including an order of probation or parole

Under 22 years old

- ☐ A copy of the education records (IEP/ARD report, Comprehensive Assessment) and results of the LA's permanency planning process including family contact information

Under 18 years old

- ☐ The results of the CRCG staffing

☐ **Respite** ☐ **Emergency Admission**

- ☐ A completed application for admission
- ☐ A written request from the LA for respite/emergency admission
- ☐ Documentation of persuasive evidence that the applicant has an intellectual disability
- ☐ Existing documentation supporting the applicant's urgent need for respite/emergency admission
- ☐ Documentation that the requested respite/emergency relief can be provided to the applicant within statutory guidelines
- ☐ A copy of any divorce decree pertaining to the applicant
- ☐ Any legal document dealing with the custody of a minor
- ☐ Current letters of guardianship, order appointing guardian and related orders, if the applicant has a guardian
- ☐ A certified copy of the applicant's birth certificate
- ☐ A copy of the applicant's immunization record
- ☐ A copy of the applicant's Social Security card
- ☐ A copy of the applicant's Medicaid and Medicare card, including Part D provider and number (if applicable) and MERP Receipt Acknowledgement
- ☐ For the applicant who is school eligible, the ARD report, IEP and Comprehensive Assessment
- ☐ For the applicant who is a minor, the results of the CRCG staffing (**for emergency admission only**)
- ☐ Any record regarding care and treatment of the applicant in a state mental health facility or a psychiatric hospital (**for emergency admission only**)
- ☐ A DID report and completed ICAP booklet and ID/RC Assessment form, if requested by the facility
- ☐ In cases of emergency or respite applications, a completed and signed Respite or Emergency Agreement will be in place before the applicant's admission.

Local Authority's IDT Report Recommending Admission to an SSLC

Individual's Name	Date

Complete this form or attach your own document with IDT Signature Sheet. If using a different format, all elements of this form must be included within the documentation. (Refer to §2.264 of the COS rule for guidance with completing this document.)

Information reviewed by the IDT that indicates individual needs SSLC placement (attach a copy of all documents cited):

How individual meets eligibility criteria (§2.255 and §2.257 of the COS rule):

Community resources and/or efforts used in attempts to serve the individual in the community:

IDT Signatures

_____ _____

_____ _____

_____ _____

Part I – Demographic/General Information

Individual's Name	Social Security Number	CARE Number

LA

LA Contact Person	Area Code and Telephone Number _ _	Area Code and Telephone Number _ _

Address (Street, City, State, ZIP)

Primary Correspondent	Relation	Area Code and Telephone Number _ _

Address (Street, City, State, ZIP)	Area Code and Telephone Number _ _

SSLC Servicing Area

Date of Birth	Guardianship Status	Level of ID	ICAP SL	ICAP LON

Individual's Current Location

Reason for SSLC Referral (brief description of services needed upon admission)

Part II – Medical/Supplemental Information

Current Behaviors (mark all the apply):

☐ Inappropriate Sexual Behavior ☐ Physical Aggression ☐ Threats/Verbal Aggression
☐ Property Destruction/Disruption ☐ Self-Injurious Behavior ☐ Unauthorized Departure
☐ Pica ☐ Other: ☐ None Noted

Current Ambulating Status (mark one):

☐ Ambulatory ☐ Wheelchair Mobile
☐ Semi-Ambulatory ☐ Non-Ambulatory

Current Health Problems (mark all the apply):

☐ Seizures ☐ Diabetes ☐ Respiratory
☐ Cardio-Vascular ☐ Gastro-Intestinal ☐ Orthopedic
☐ Other: _____ ☐ None Noted

Current Diet Texture (mark all that apply):

☐ Solid ☐ Chopped
☐ Ground ☐ Pureed

Current Diet Type (mark all the apply):

☐ Regular ☐ High Calorie ☐ Diabetic
☐ Low Fat/Cholesterol Free ☐ Low Sodium ☐ Calorie Restricted (1500, 1200, etc.)
☐ Other: _____

Current Toileting (mark one):

☐ Independent ☐ Physical Assistance ☐ Verbal Prompt/Reminder
☐ Toileting Schedule (every 2 hours) ☐ Incontinent ☐ Catheter
☐ Other: _____

Adaptive Equipment (mark all the apply):

☐ Prescribed Eye Glasses ☐ Hearing Aid/Amplification ☐ Communication Board/Book
☐ Walker/Cane ☐ Wheelchair ☐ Helmet
☐ Hospital Bed/Specialized Bedding/Rails ☐ Orthopedic Braces – Location: _____

Specialized Therapy (mark all the apply):

☐ Occupational ☐ Physical ☐ Speech and Language
☐ Psychiatric/Counseling ☐ Orientation and Mobility ☐ Audiological
☐ Other: _____ ☐ None Noted

Special Needs (mark all the apply):

☐ Oxygen ☐ Lift ☐ G-Tube/J-Tube
☐ Dialysis ☐ Diabetic Monitoring ☐ Respiratory Services
☐ Nebulizer ☐ TED Hose ☐ One-to-One Supervision
☐ Line of Sight Supervision ☐ Other: _____ ☐ None Noted

Unresolved Medical Conditions

Individual's Current Diagnosis:

Individual's Current Medication(s) and Dosage(s):

Individual's Medication History:

Individual's Family History

Include age(s) of family member(s) if possible. Mark "Yes" or "No" for family member(s) illnesses.

	Mother	Father	Sister(s)	Brother(s)
Age(s)				
Illnesses				
Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Hypertension	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Respiratory	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Gastro-Intestinal	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Cardio-Vascular	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Seizure Disorder	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Orthopedic	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Other	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Further Explanations or Notations Related to Health/Medical Information of Family Member(s)

Signature of Person Assisting with Part II

Date

Signature of Physician

Date

Printed Name of Physician

Part III – Financial Information

Texas Department of Aging and Disability Services
Property and Financial Statement

Intellectual Disability Services

Return to:

Complete all spaces. Indicate if requested information is unknown, not applicable or none. Circle or check the correct answer where necessary.

1. Individual's Information

Individual Name	Case Number	Social Security Number
Address (Street, City, State, ZIP)		
Place of Birth	Date of Birth	Area Code and Telephone Number – –
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	U.S. Citizen ☐ Yes ☐ No	Sex ☐ Male ☐ Female

2. Hospitalization Insurance Coverage for Individual

Policyholder's Name		Policyholder's Social Security Number
Insurance Company		Policy Number
Address (Street, City, State, ZIP)		
Employer (Group Policy)	Group Number	Area Code and Telephone Number – –
Place of Birth	Date of Birth	Area Code and Telephone Number – –
Pre-Certification Required ☐ Yes ☐ No	Pre-Certification Area Code and Telephone Number – –	
Other Coverage ☐ Yes ☐ No (If "Yes," please provide insurance information on Page 10, Section 10.)		

3. Individual's Medicare/Medicaid

Medicare Number		Name Shown on Card	
Part A ☐ Yes ☐ No	Part A Effective Date	Part B ☐ Yes ☐ No	Part B Effective Date
Medicaid Recipient Number	Name Shown on Card		Medicaid Effective Date

4. Champus Coverage for Individual

Sponsor's Name	Relationship to Individual	Service Number	Rank/Grade
Active/Retired	ID Card Number	Card Issue Date	Expiration Date

5. Individual's Guardianship (Attach copy of application for guardianship, letter of guardianship and most recent annual account.)

Is there a court-appointed guardian of the individual's estate or person? ☐ Estate ☐ Person ☐ Both	County	Probate Number
Guardian's Name	Relationship to Individual	Area Code and Telephone Number – –
Address (Street, City, State, ZIP)		Work Area Code and Telephone Number – –

6. Individual's Benefits and Income Information

		Monthly Income	Claim Number	Paid To
Social Security Benefits	☐ Yes ☐ No			
Veteran's Benefits	☐ Yes ☐ No			
Civil Service Benefits	☐ Yes ☐ No			
Supplemental Security Income	☐ Yes ☐ No			
Retirement	☐ Yes ☐ No			
Rental/Lease Income	☐ Yes ☐ No			
Child Support (Cause Number)	☐ Yes ☐ No			
Survivor Benefits	☐ Yes ☐ No			
Other:	☐ Yes ☐ No			
		Annual Income	**Account Number**	**Paid To**
Trust Income	☐ Yes ☐ No			
Interest Income	☐ Yes ☐ No			
Dividends	☐ Yes ☐ No			
Royalty Income	☐ Yes ☐ No			

7. Individual's Real and Personal Property

		Value	Amount Owed	Number of Co-Owners	Property Location (County, State)
Home	☐ Yes ☐ No				
Acreage	☐ Yes ☐ No				
Rental Property	☐ Yes ☐ No				
Mineral Rights	☐ Yes ☐ No				
Other:	☐ Yes ☐ No				
		Value	**Account Number**	**Location**	
Checking Account	☐ Yes ☐ No				
Savings Account	☐ Yes ☐ No				
Certificates of Deposit	☐ Yes ☐ No				
Bonds and Securities	☐ Yes ☐ No				
Other:	☐ Yes ☐ No				
Trust (attach copy)	☐ Yes ☐ No				
Name and Address of Trustee					

8. Burial Arrangements Owned by Individual (Please attach copies of any or all contracts or policies.)

Burial Contract ☐ Yes ☐ No	Location		Value
Burial Space ☐ Yes ☐ No	Location		
Burial Fund ☐ Yes ☐ No	Location		Value
Burial Insurance ☐ Yes ☐ No	Face Value	Cash Value	Company Name
Company Address (Street, City, State, ZIP)			
Life Insurance ☐ Yes ☐ No	Face Value	Cash Value	Company Name
Company Address (Street, City, State, ZIP)			

9. Family Information

Father's Name			Social Security Number		
Address (Street, City, State, ZIP)					
Date of Birth	Place of Birth	Date of Death	Place of Death		
Area Code and Telephone Number – –	Work Area Code and Telephone Number – –	Retired ☐ Yes ☐ No	Disabled ☐ Yes ☐ No	Survivor Benefits ☐ Yes ☐ No	
Military Service ☐ Yes ☐ No From: to		Eligible for Benefits ☐ Yes ☐ No	Service Number		
Civil Service ☐ Yes ☐ No From: to		Eligible for Benefits ☐ Yes ☐ No	Claim Number		
Railroad Service ☐ Yes ☐ No From: to		Eligible for Benefits ☐ Yes ☐ No	Claim Number		
Mother's Name			Social Security Number		
Address (Street, City, State, ZIP)					
Date of Birth	Place of Birth	Date of Death	Place of Death		
Area Code and Telephone Number – –	Work Area Code and Telephone Number – –	Retired ☐ Yes ☐ No	Disabled ☐ Yes ☐ No	Survivor Benefits ☐ Yes ☐ No	
Military Service ☐ Yes ☐ No From: to		Eligible for Benefits ☐ Yes ☐ No	Service Number		
Civil Service ☐ Yes ☐ No From: to		Eligible for Benefits ☐ Yes ☐ No	Claim Number		
Railroad Service ☐ Yes ☐ No From: to		Eligible for Benefits ☐ Yes ☐ No	Claim Number		
Stepfather's Name			Area Code and Telephone Number – –		
Address (Street, City, State, ZIP)					
Stepmother's Name			Area Code and Telephone Number – –		
Address (Street, City, State, ZIP)					

10. Other Information (Please describe any additional financial assets in the space below or on the back of this form, including any pending estate distributions or personal injury settlements.)

I certify that the foregoing information is true and correct to the best of my knowledge.

Signature _____ Date _____

Printed Name	Relationship to Individual	Area Code and Telephone Number – –
Address (Street, City, State, ZIP)		Work Area Code and Telephone Number – –